MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01442 01439

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 311 Marshall Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Edward — Last: BISHOP, Sr.

4. DATE OF DEATH: Month: January — Day: 23 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 11,1909

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months: 3, Days: 12 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner - Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Auto - Body Shop

11. BIRTHPLACE (County & State, or foreign country): Centreville, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: R. Kennard Bishop

14. MOTHER'S MAIDEN NAME: Vicie O. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-10-7227

17. INFORMANT: Mrs. Grace C. Bishop (Wife) — Address: 311 Marshall Street, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 12 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Acute myocardial failure — 48 hours
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Tri-malleolar fracture, right ankle

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 9, 1967, to January 23 19 67 that (I) (we) last saw the deceased alive on January 23 1967, and that death occurred at 2:10 P M, from causes and on the date stated above.

22a. SIGNATURE: C. H. Winnacott M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-23-67

22c. PHYSICIAN'S NAME (Type): Dr. C. H. Winnacott

22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 25, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01443 01441

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temperanceville, VA
d. STREET ADDRESS: Temperanceville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Milton Middle Dennis Last Bodley
4. DATE OF DEATH: Month January Day 25 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/28/1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumberman
10b. KIND OF BUSINESS OR INDUSTRY: Lumber Mfg.
11. BIRTHPLACE (County & State, or foreign country): Accomack, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME: Charles E Bodley
14. MOTHER'S MAIDEN NAME: Bewiah Bodley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): World War I
16. SOCIAL SECURITY NO.:
17. INFORMANT: Avalon Bodley Address: Temp. Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROSIS - GENERAL — INDEF.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 1/5, 1967, to 1/25, 1967, that (I) ~~(we)~~ last saw the deceased alive on 1/25 1967, and that death occurred at 11:30 ~~A~~ P.M., from causes and on the date stated above.

22a. SIGNATURE: John M. Bloxom III — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): JOHN M. BLOXOM III
22d. ADDRESS: MEDICAL CTR. SALISBURY, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/28/67
23c. NAME OF CEMETERY OR CREMATORY: Downings
23d. LOCATION (City or Town) (County) (State): Oak Hall, Accomack, Va.
24. FUNERAL DIRECTOR: H. N. Fox Funeral Home ADDRESS: Temp. Va.
25a. REC'D BY REGISTRAR DATE: JAN 30 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01444 Item 9 Film G365 2/13/67 mh 01440

1. **PLACE OF DEATH**
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 36 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MD. b. COUNTY: Wic.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
d. STREET ADDRESS: 729 Richmond Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: EDWARD Middle: — Last: BOOKER

4. **DATE OF DEATH**: Month: 1 Day: 21 Year: 1967

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/15/06

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-11-0911

17. INFORMANT: Rosella Booker Address: 729 Richmond Ave Salisbury, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arteriosclerosis — Indefinite
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Jan 19 65 to 21 Jan 19 67, that (I) (we) last saw the deceased alive on 21 Jan 19 67, and that death occurred at 5:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: E A Purnell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 25 Jan 67

22c. PHYSICIAN'S NAME (Type): E A Purnell, MD.

22d. ADDRESS: 8 W. Main St. Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/26/67

23c. NAME OF CEMETERY OR CREMATORY: Green Acres

23d. LOCATION (City, town or county): Salisbury (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: West Funeral Home, Salisbury, Md

25a. REC'D BY REGISTRAR DATE: FEB 6 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01445

CERTIFICATE OF DEATH

01442

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: Market Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: C. — Last: Bowden
4. DATE OF DEATH: Month: January — Day: 13 — Year: 1967
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/19/1900
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Policeman
10b. KIND OF BUSINESS OR INDUSTRY: City
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Bowden
14. MOTHER'S MAIDEN NAME: Martha Shockley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): --------
16. SOCIAL SECURITY NO.: 219144197A
17. INFORMANT — Address: Mamie Bowden, Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Supraventricular Tachycardia — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
DUE TO (b): Electrolyte Imbalance — 3 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Uremia (K-S-W disease) — 4 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus ; Gangrene of Lt foot
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 19 66 to Jan, 19 67, that (I) (we) last saw the deceased alive on Jan 13 19 67, and that death occurred at 5:22 P M, from causes and on the date stated above.

22a. SIGNATURE: David Raft M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): DAVID RAFAT
22d. ADDRESS: Snow Hill MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/16/67
23c. NAME OF CEMETERY OR CREMATORY: Bowen Methodist
23d. LOCATION (City or Town) (County) (State): Newark, Maryland

24. FUNERAL DIRECTOR: Snow Hill. Maryland — ADDRESS
25a. REC'D BY REGISTRAR — DATE: JAN 17 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01446

CERTIFICATE OF DEATH

01443

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Del. — b. COUNTY: Sussex ✓
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): George town 4 6.3
d. STREET ADDRESS: R.F.D. 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jeanette — Middle: — Last: Broughton
4. DATE OF DEATH: Month: January — Day: 7 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 10, 1950
9. AGE (In years last birthday): 16 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Del.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles White
14. MOTHER'S MAIDEN NAME: Elsie Broughton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: John Broughton Route 5 Georgetown, Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart Failure.
7542
DUE TO (b): Pulmonary Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Interventricular septal defect
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congenital hemolytic anemia (ovalocytosis)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1-6-, 1967 to 1-7-, 1967 that (I) (~~was~~ last saw the deceased alive on 1-7-1967 and that death occurred at 6:45 M, from causes and on the date stated above.

22a. SIGNATURE: James L. Coppedge M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-7-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: Medical Center Salisbury Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-14-67
23c. NAME OF CEMETERY OR CREMATORY: Friendship Cem.
23d. LOCATION (City or Town) (County) (State): Wattsville Accomack Va.

24. FUNERAL DIRECTOR: Samuel Long
ADDRESS: New Church, Va.
25a. REC'D BY REGISTRAR — DATE: JAN 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01447 01444

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in ID 1/9/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
d. STREET ADDRESS: Railroad Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BERTIE Middle ESTHER Last BROWN
4. DATE OF DEATH: Month JANUARY Day 10 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 2, 1900
9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR Months 0 Days 8 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Hebron, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles Wesley Phippin
14. MOTHER'S MAIDEN NAME: Mary Ellen Parsons
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 216-16-7601
17. INFORMANT Address: Mr. Charles Henry Brown (Husband) Railroad Avenue, Hebron, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to _____, 19__, that (I) (we) last saw the deceased alive on _____, 19__, and that death occurred at 7:05 M, from causes and on the date stated above.

22a. SIGNATURE: David J. Gilmore M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan. 10 /1967
22c. PHYSICIAN'S NAME (Type): Dr. David J. Gilmore
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 13, 1967
23c. NAME OF CEMETERY OR CREMATORY: Hebron Cemetery
23d. LOCATION (City or Town) (County) (State): Hebron, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: JAN 12 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01448

CERTIFICATE OF DEATH

01445

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.n 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 mon - 13 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town): Salisbury
d. STREET ADDRESS: 511 Douglas Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Marion — Middle: M. — Last: Brown

4 DATE OF DEATH: January 1, 1967

5 SEX: Female

6 COLOR OR RACE: Colored

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 11/4/1868

9. AGE (In years last birthday): 98 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUA. OCCUPATION (Give k nd of work done during most of working life, even if retired): Domestic

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roland Dashiell

14 MOTHER'S MAIDEN NAME: Emley Quinton

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dates of service)

16. SOCIAL SECURITY NO: 220-52-7982

17 INFORMANT: Dolly Curtis — Address: 622 Lake St. Salis. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 W
DUE TO (b): Dec. cerebral thrombosis — 3 Mo.
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last: 332X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/19/66, 19__ to January1, 19 67 that (I) (we) last saw the deceased alive on January 1, 19 67, and that death occurred at 10:30 P.M., from causes and on the date stated above.

22a SIGNATURE: L. V. Maldve, M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. X

22b DATE SIGNED: 1/2/67

22c PHYSICIAN'S NAME (Type): L. V. MALDVE, MDD.

22d ADDRESS: Deer's Head State Hospital

23a BURIAL, CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: 1/6/1967

23c. NAME OF CEMETERY OR CREMATORY: Mount Nebo

23d LOCATION (City or Town) (County) (State): Columbia Del.

24. FUNERAL DIRECTOR: Charles A. Stewart — ADDRESS: Salis. Md.

25a. REC'D BY REGISTRAR DATE: JAN 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01449

CERTIFICATE OF DEATH

01446

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: since 7/29/66
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pine Bluff State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: BaltimoreCity
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Md.
d. STREET ADDRESS: 23 Eutaw Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Archie — Middle: - — Last: Burrell

4 DATE OF DEATH: Month: January — Day: 20 — Year: 19 67

5 SEX: male

6 COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 6, 1932

9 AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: -

11 BIRTHPLACE (County & State, or foreign country): Baltimore City, Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Johnnie Burrell

14 MOTHER'S MAIDEN NAME: Edna Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: 217-14-0464

17. INFORMANT Address: Records of Pine Bluff State Hospital, Salisbury, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
102.1
INTERVAL BETWEEN ONSET AND DEATH: 11 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I)(this hospital) attended the deceased from July 29, 1966, to Jan. 20, 1967 that (I)(we) last saw the deceased alive on Jan. 20 19 67 and that death occurred at 11:15 a.m., from causes and on the date stated above.

22a. SIGNATURE: E. P. Ritchings — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: Jan. 20, 1967

22c PHYSICIAN'S NAME (Type): E. P. Ritchings, M.D.

22d. ADDRESS: Pine Bluff State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-20-67

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City or Town) (County) (State): Balto Co. Md.

24. FUNERAL DIRECTOR: West Funeral Home — ADDRESS

25a RECD BY REGISTRAR DATE: JAN 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01450

CERTIFICATE OF DEATH

01447

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAMD — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PRINCESS ANNE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ELEANOR — Middle: W. — Last: CLARK
4. DATE OF DEATH: Month: JANUARY — Doy: 13 — Year: 1967
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 15, 1885
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Princess Anne Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Adams
14. MOTHER'S MAIDEN NAME: Rose Dryden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mr. Morris F. Adams Pr-Anne Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocard Insufficiency
DUE TO
(b):
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Few days
410.3

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-11, 1967 to 1-13, 1967 that (I) (we) last saw the deceased alive on 1-13 1967, and that death occurred at 8:45 M, from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-13-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/16/67
23c. NAME OF CEMETERY OR CREMATORY: Manokin Pres. Cemetery
23d. LOCATION (City or Town) (County) (State): Princess Anne Md

24. FUNERAL DIRECTOR — ADDRESS: Leon R. Wilson — Princess Anne
25a. REC'D BY REGISTRAR DATE: JAN 16 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01451

CERTIFICATE OF DEATH

01448.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Md. — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First John — Middle — Last Conner.
4. DATE OF DEATH: Month January — Day 11 — Year 1967

5. SEX: male
6. COLOR OR RACE: Negro
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 10 1902
9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Peter Conner
14. MOTHER'S MAIDEN NAME: Bessie Handy

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO: 217-07-3990
17. INFORMANT: Bernice Conner — Address: Girdletree, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Supra ventricular Tachycardia — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Pneumococcal pericarditis — 5 days
DUE TO (c): and septicemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple Myeloma.

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 1966 to Jan, 1967 that (I) (we) last saw the deceased alive on Jan 4 1967, and that death occurred at 3:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): DAVID RAFAT
22d. ADDRESS: Snow Hill

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-14-67
23c. NAME OF CEMETERY OR CREMATORY: Coolspring Cem.
23d. LOCATION (City or Town) (County) (State): Girdletree Wor. Md.

24 FUNERAL DIRECTOR: Samuel Lowe — ADDRESS: New Church, Va.
25a. REC'D BY REGISTRAR DATE JAN 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (II)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01452 01449

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 19 DAYS

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND b. COUNTY: WICO.
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): SALISBURY
d. STREET ADDRESS: 817 PENN. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

3 NAME OF DECEASED (Type or print): First MARY Middle CULVER Last COULTER

4. DATE OF DEATH: Month JANUARY Day 2 Year 19 67

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 20, 1915
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOOKKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: Oil Supply
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LARRY J. CULVER
14. MOTHER'S MAIDEN NAME: MINNIE CALLOWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 220-09-1588
17. INFORMANT: N.L. CULVER Address: PEMBERTON DR. SALISBURY MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Hepatic Coma - — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Cirhosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Chronic Alcoholism — years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED White at work ☐ Not White at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-13, 1966 to 1-2, 1967, that (I) (we) last saw the deceased alive on 1-2 1967, and that death occurred at 2:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 2 January '67
22c. PHYSICIAN'S NAME (Type): JOSEPH C. FITZGERALD, MD.
22d ADDRESS: MEDICAL CTR. SALISBURY, MD.

23a BURIAL CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 1/4/1967
23c NAME OF CEMETERY OR CREMATORY: PARSONS CEMETERY
23d. LOCATION (City or Town) (County) (State): SALISBURY, MD.

24. FUNERAL DIRECTOR: HILL FUN. HOME ADDRESS: SALISBURY, MD.
25a. REC'D BY REGISTRAR DATE: JAN 5 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01453 Item 8 Form 5003 2/6/67 mn 01450

1. **PLACE OF DEATH** a. COUNTY: Wic. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dr. Emp. Hosp

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) a. STATE: MD b. COUNTY: WIC
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY. MD.
d. STREET ADDRESS: Dixon Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Amelia Middle: G. Last: Cuff
4. **DATE OF DEATH**: Month: — Day: 5 Year: 19 67

5. SEX: Female
6. COLOR OR RACE: NeRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 4 1883
9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Wicomico
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unk
14. MOTHER'S MAIDEN NAME: unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: unk
17. INFORMANT: Lucille Crump. Address: Baltimore, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Atrial Fibrillation - Influenza Erysipelas
DUE TO (b): Cardiac Decompensation
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Low Grade Pneumonia

INTERVAL BETWEEN ONSET AND DEATH: Several Days / Unknown / Few Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 3, 1967 to Jan. 8, 1967 that (I) (we) last saw the deceased alive on Jan. 8, 1967, and that death occurred at 8:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: G. Herbert Sembly M.D.
22b. DATE SIGNED: Jan. 16, 1967
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): G. Herbert Sembly
22d. ADDRESS: Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-13-67
23c. NAME OF CEMETERY OR CREMATORY: Bloss Hill Cem
23d. LOCATION (City, town or county): Parsonsburg (State): Md

24 FUNERAL DIRECTOR'S SIGNATURE: Dowden Dewitt ADDRESS:
25a. REC'D BY REGISTRAR DATE: JAN 13 1967
25b. REGISTRAR'S SIGNATURE: Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01456 Items 2, 25d Film 6365 1/24/67 mh 01451

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural MAAdela
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Maple Shade Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural MAAdela
d. STREET ADDRESS: Niece's Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First HELEN Middle G. Last DEACON
4. DATE OF DEATH: Month JAN. Day 15 Year 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Feb. 9, 1883
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Burlington New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Edward F. Gilbert
14. MOTHER'S MAIDEN NAME: EMAline Hippencott
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Sadie Gilbert Address: MAAdela, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8 hr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): b. diabetes — 15
DUE TO (c): Arterio sclerosis — 10
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1954, to 1/15, 1967, that (I) (we) last saw the deceased alive on April 1/14 1967, and that death occurred at 7 A.M. from the causes and on the date stated above.

22a. SIGNATURE: H.S. Kuhlman M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/16/67
22c. PHYSICIAN'S NAME (Type): Dr H.S. KUHLMAN
22d. ADDRESS: SNOWTOWN, MARYland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-18-67
23c. NAME OF CEMETERY OR CREMATORY: St. Andrews Church
23d. LOCATION (City, town or county) (State): Mt. Holly, N. J.

24. FUNERAL DIRECTOR: MAurice E. NewNamJON ADDRESS: EASton, Md.
25a. REC'D BY REGISTRAR DATE: JAN 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01455 — 01452

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md.
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IVA — Middle: M. — Last: Disharoon
4. DATE OF DEATH: Month: January — Day: 19 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/6/1889
9. AGE (In years ost birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Thomas Messick
14. MOTHER'S MAIDEN NAME: Amelia Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 217-05-3157
17. INFORMANT: A. Louise Taylor — Address: Salisbury, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
4 11 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-16, 1967, to 1-19, 1967, that (I) (we) last saw the deceased alive on 1-18 1967, and that death occurred at 9:40 A M, from causes and on the date stated above.

22a. SIGNATURE: Hubert R. White, Jr. — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 1-19-67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Fruitland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/22/67
23c. NAME OF CEMETERY OR CREMATORY: Allen Cemetery
23d. LOCATION (City or Town) (County) (State): Allen, Md.

24. FUNERAL DIRECTOR: C. W. Posey — ADDRESS: Pivalve, Md.

25a. REC'D BY REGISTRAR DATE: JAN 24 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and, in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01456 — Item-1b Film 0305 1/30/67 mh — 01453

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: All Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 728 Lake St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 728 Lake Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: J. — Last: DORMAN

4. DATE OF DEATH: Month: 1 — Day: 3 — Year: 1968

5. SEX: M.

6. COLOR OR RACE: A.A

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-22-1888

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction

10b. KIND OF BUSINESS OR INDUSTRY: State Road

11. BIRTHPLACE (County & State, or foreign country): Head-of-the-Creek

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Dorman

14. MOTHER'S MAIDEN NAME: Henrietta Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217-10-3653

17. INFORMANT: Address: Jamanna Dorman 728 Lake St. Sal.'s.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular renal disease
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4/42X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 19[illegible] to Jan. 3, 1967, that (I) (we) last saw the deceased alive on Dec 22 1966, and that death occurred at 2:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip A. Insley M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-4-67

22c. PHYSICIAN'S NAME (Type): Philip A. Insley

22d. ADDRESS: Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: JAN. 7, 1967

23c. NAME OF CEMETERY OR CREMATORY: Head-of-the Creek

23d. LOCATION (City, town or county) (State): Quantico, Md.

24. FUNERAL DIRECTOR: Volkey's Fun. Home — ADDRESS: Jersey Rd, Rt #2 Salisbury, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 10 1967

25b. REGISTRAR'S SIGNATURE: Wesley Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01457

01454

1 PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): DOA Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland b COUNTY: Wicomico
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d STREET ADDRESS: 513 E. Locust St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOHN Middle FRANCIS Last DORSEY
4 DATE OF DEATH: Month 1-5-67 Day Year 19
5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Aug. 18,1893
9 AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months 4 Days 17
IF UNDER 24 HRS: Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipbuilder-employee
10b KIND OF BUSINESS OR INDUSTRY: Shipyard
11 BIRTHPLACE (State or foreign country): Somerset County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME: William Dorsey
14. MOTHER'S MAIDEN NAME: Annie Ross
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 217-10-3772
17 INFORMANT: Mr. Marion T. Dorsey (Son) Address: 511 E. Locust Street, Salisbury, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Arteriosclerotic cardio-vascular disease — Years
DUE TO
(c):
7401

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): N/A
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: January 6, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Jan. 8, 1967
23c NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d LOCATION (City or Town) (County) (State): Salisbury, Maryland
24 FUNERAL DIRECTOR ADDRESS: Holloway Funeral Home, Salisbury, Md.
25a REC'D BY REGISTRAR DATE: JAN 9 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

Items 18&21 Film 335 2-2

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01458

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01455

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital D.O.A.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 212 Record Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First OLIVER — Middle FRANCIS — Last DOWNES

4 DATE OF DEATH: Month January — Day 18 — Year 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Aug. 14, 1920

9 AGE (In years last birthday): 46 yrs
IF UNDER 1 YEAR: Months 4 — Days 4
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY: Cemetery

11 BIRTHPLACE (State or foreign country): Sussex County, Delaware

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Robert E. Downes

14 MOTHER'S MAIDEN NAME: Julia Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes give war or dates of service): War II

16 SOCIAL SECURITY NO.:

17 INFORMANT (Address): Miss Mildred A. Diggs (Friend)
212 Record Street, Salisbury, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Broncho pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Status Epilepticus
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Hours — Years

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer, M.D.

EXAMINER'S NAME (Type): Dr. Earl L. Royer
Address (Street, city, town, or county): 409 Camden Avenue, Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: January 19 /1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Jan. 20, 1967

23c NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

23d LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
ADDRESS:

25a. REC'D BY REGISTRAR DATE: JAN 20 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01459

CERTIFICATE OF DEATH

01456

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 103 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Rt. 4, Mt. Hermon Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Norman — Middle: Henry — Last: ELLIS

4 DATE OF DEATH: Month: January — Day: 17 — Year: 1967

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Jan. 9, 1905

9 AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months: 0 — Days: 8 — IF UNDER 24 HRS: Hours: — Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b KIND OF BUSINESS OR INDUSTRY: Farming

11 BIRTHPLACE (County & State, or foreign country): Wicomico County, Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Henry Ellis

14. MOTHER'S MAIDEN NAME: Annie Belle Dykes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT (Address): Mrs. Lula May Smith (Sister) Willards, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10-14 days
DUE TO (b): Inoperable CA of right mid lung with metastases (kidney, liver) — One Year
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tbc., arrested (14 years)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October 6, 1966, to January 17, 1967, that (I) (we) last saw the deceased alive on January 17 1967, and that death occurred at 7:29A M, from causes and on the date stated above.

22a. SIGNATURE: C. H. Winnacott — M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1/17/67

22c. PHYSICIAN'S NAME (Type): Dr. C. H. Winnacott

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24 FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 20 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01460

CERTIFICATE OF DEATH

01457

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Since 1/6/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pine Bluff State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Rt.4, Merritt Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Dorothy Katherine Middle (Reid) Last Farlow
4. DATE OF DEATH: Month January Day 13 Year 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 17, 1919
9. AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months 10 Days 26
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Worcester Co. Pocomoke City, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Wm. Reid
14. MOTHER'S MAIDEN NAME: Katherine Linton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. J. Franklin Farlow, R.D.#4 Address: Records of Pine Bluff State Hospital Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs
002.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Jan. 6, 19 67 to Jan. 13, 19 67, that (I) (we) last saw the deceased alive on Jan. 13 19 67, and that death occurred 5:50a M, from causes and on the date stated above.

22a. SIGNATURE: E. P. Ritchings — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 1/14/67
22c. PHYSICIAN'S NAME (Type): E. P. Ritchings
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: JAN 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

4 . 1 M

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01461

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01458

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsville
d. STREET ADDRESS: R.D. #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
MAGGIE	ETHEL	FARLOW	January	17	1967

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Female	White	WIDOWED [X]	March 24, 1881	85 yrs	9	23		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
House work	at home	Wicomico County, Maryland	USA

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Nelson Baker	Mary Bratten

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service	16 SOCIAL SECURITY NO	17 INFORMANT Address
No	217-48-2071	Mr. William L. Farlow (Son) 5 Baker Street, Berlin, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 7 hours
DUE TO (b): Fx. Rt Hip — 1 month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO [X]

20a EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING ☐ CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18)				
	Fall at home				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d INJURY OCCURRED While at work ☐ Not While at work [X]	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
5 p.m. 12-14 1966		home	Pittsville	Wic	Md

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D

EXAMINER'S NAME (Type): Dr. Earl L. Royer
409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)

22. DATE SIGNED: January 19 /1967

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Jan. 20, 1967	Pittsville Cemetery	Pittsville, Maryland

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MARYLAND	JAN 20 1967	J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01462

CERTIFICATE OF DEATH

01459

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 32 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WORCESTER
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
   d. STREET ADDRESS: HARBOR ROAD
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Carrie Middle Wendall Last Fisher

4. DATE OF DEATH: Month January Day 1 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAR. 11, 1910

9. AGE (In years last birthday): 56 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): OCEAN VIEW DEL

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK C. PHILLIPS

14. MOTHER'S MAIDEN NAME: LULA DERRICKSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A (If yes give war or dates of service) No

16. SOCIAL SECURITY NO

17. INFORMANT: Address: Mr. Everett Fisher Ocean City Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
   DUE TO (b):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 12-30-66, 19__ to 1-1-, 1967, that (I) (we) last saw the deceased alive on 1-1, 19 67, and that death occurred at [illegible] M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-17-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/7/67

23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

23d. LOCATION (City or Town) (County) (State): BERLIN WORC. MD

24. FUNERAL DIRECTOR: Bruce A Burbage — ADDRESS: Berlin Md

25a. REC'D BY REGISTRAR DATE: JAN 5 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in penci in item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01463

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01460

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital D.O.A.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
d. STREET ADDRESS: Main Street, P.O. Box 253
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle ALVAH — Last FISHER

4 DATE OF DEATH: Month January — Day 23 — Year 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Nov. 20, 1933

9 AGE (In years last birthday): 33 yrs
IF UNDER 1 YEAR: Months 2 — Days 3
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine operator

10b KIND OF BUSINESS OR INDUSTRY: Chemical Co.

11 BIRTHPLACE (State or foreign country): Baltimore, Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Carl MacPherson Fisher

14. MOTHER'S MAIDEN NAME: Mildred Vincent Ashley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Mrs. Mary Ann Fisher (Wife) P.O. Box 253, Fruitland, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Ex. P.S. Kidd
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Pilot of Plane (crashed)

20c TIME OF INJURY Month, Day, Year: Hour 5:15 pm — 1 23 1967

20d INJURY OCCURRED While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm

20f (City or town): Fruitland (County): Wic (State): Md

21 I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D

EXAMINER'S NAME (Type): Dr. Earl L. Royer

Address (Street, city, town, or county): 409 Camden Avenue, Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: January 24 /1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Jan. 26, 1967

23c NAME OF CEMETERY OR CREMATORY: Allen Church Cemetery

23d LOCATION (City or Town) (County) (State): Allen, Wico. Co., Maryland

24 FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a REC'D BY REGISTRAR DATE: JAN 27 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01464 01461

1. PLACE OF DEATH
a. COUNTY: Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UPPER FAIRMOUNT
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Linwood Middle T. Last Ford
4. DATE OF DEATH: Month JANUARY Day 15 Year 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 6, 1882
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED STREET CAR
10b. KIND OF BUSINESS OR INDUSTRY: CONDUCTOR
11. BIRTHPLACE (County & State, or foreign country): UPPER FAIRMOUNT, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: THOMAS FORD
14. MOTHER'S MAIDEN NAME: CLARA FORD
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: MRS. CLARA HUBBARD ARDMORE, PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure.
DUE TO (b): A.S.C.V.D. & pneumonia bilateral
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Thrombosis superior mesenteric vein & gangrene of bowel, Thrombosis splenic vein
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-7-67, 19__ to 1-15-67, 19__, that (I) (we) last saw the deceased alive on 1-15-67 19__, and that death occurred at 6:22 A.M., from causes and on the date stated above.

22a. SIGNATURE: Joseph C. Ford, Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-15-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: Medical Center Salisbury Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/19/1967
23c. NAME OF CEMETERY OR CREMATORY: FAIRMOUNT CEMETERY
23d. LOCATION (City or Town) (County) (State): FAIRMOUNT, MD.

24. FUNERAL DIRECTOR ADDRESS: LEVIN R. WILSON PRINCESS ANNE, MD.
25a. REC'D BY REGISTRAR DATE: JAN 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 (M)

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01465

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01462

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 907 Cooper Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NEVINS — Middle THOMAS — Last FOSKEY
4. DATE OF DEATH: Month January — Day 23 — Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 21, 1940
9. AGE (In years last birthday): 26 yrs
IF UNDER 1 YEAR: Months 4 — Days 2
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Nylon Plant
11. BIRTHPLACE (State or foreign country): Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nevins Albert Foskey
14. MOTHER'S MAIDEN NAME: Lillian Virginia Beauchamp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT (Address): Mrs. Lillian Luffman Foskey (Wife) 907 Cooper St., Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
I / V IMMEDIATE CAUSE (a): Fx of Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Passenger in Plane (Crashed)
20c. TIME OF INJURY Month, Day, Year: Hour 5:15 pm — 1 23 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☑
20e. PLACE OF INJURY (Home farm factory street off co bldg, etc.): Farm
20f. (City or town): Fruitland (County): Wic (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D
EXAMINER'S NAME (Type): Dr. Earl L. Royer
Address (Street, city, town, or county): 409 Camden Avenue, Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: January 24 /1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 26, 1967
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: JAN 27 1967
25b. REGISTRAR'S SIGNATURE: Earl L. Royer

FOR STATE HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01466 — 01463

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Wicomico
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d STREET ADDRESS: Morris Leonard Rd.
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First JOHN — Middle EWIN — Last FOX
4 DATE OF DEATH: Month 1 — Day 1 — Year 67 (19)

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 5-4-78
9 AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months 7 — Days 27
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11 BIRTHPLACE (State or foreign country): Missouri
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Unk. Fox
14 MOTHER'S MAIDEN NAME: (Unk.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16 SOCIAL SECURITY NO:
17. INFORMANT: Mr. James R. Bengel (Grandson) — Address: 182 Bridge Street, Phoenixville, Pa. 19460

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO
(b): Arteriosclerotic cardio-vascular disease — Years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of right femur, intertrochanteric

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18): Fell at home.
20c TIME OF INJURY Hour a.m./p.m.: Approx. — Month Day Year: 12-7-66
20d INJURY OCCURRED While at work ☐ Not While at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home
20f (City or town) (County) (State): Parsonsburg, Wicomico, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: January 9, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b DATE THEREOF: Jan.6,1967
23c. NAME OF CEMETERY OR CREMATORY: University Hospital
23d LOCATION (City or Town) (County) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR — ADDRESS: Holloway Funeral Home, Salisbury, Md.
25a. RECD BY REGISTRAR — DATE: JAN 10 1967
25b REGISTRAR'S SIGNATURE:

VR A15ME (5)
6M 1/66

Two-for-one Film G384 1/13/67 mh

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01467

CERTIFICATE OF DEATH

01464

1 PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland
b COUNTY: Wicomico
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Allen
d. STREET ADDRESS: R.F.D. #2
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Baby — Middle: — Last: GALE

4 DATE OF DEATH: Month: JANUARY — Day: 10 — Year: 19 67

5 SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/10/1967

9 AGE (In years lost birthday) yrs:

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: 4 — Min: 29

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State, or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Bethena Gale R.F.D.2 Eden Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Immaturity (1 lb 7 oz)
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
776K
INTERVAL BETWEEN ONSET AND DEATH: 4 hr 29 m.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/10, 1967 to 1/10, 1967, that (I) (we) last saw the deceased alive on 1/10 19 67, and that death occurred at 11:45 AM, from causes and on the date stated above.

22a. SIGNATURE: W.S. Coulson — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d ADDRESS:

23a BURIAL, CREMATION, REMOVAL (Specify): burial

23b DATE THEREOF: 1/13/1967

23c NAME OF CEMETERY OR CREMATORY: Allen

23d. LOCATION (City or Town) (County) (State): Allen Md.

24 FUNERAL DIRECTOR — ADDRESS: Chester F. Stewart Salisbury Md

25a REC'D BY REGISTRAR DATE: JAN 20 1967

25b REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01468

CERTIFICATE OF DEATH

01465

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in 1 D 1/10/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Tilghman Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NOAH; Middle JAMES; Last GORDY

4. DATE OF DEATH: Month January; Day 17; Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 12, 1889

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months 7; Days 5
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - employee

10b. KIND OF BUSINESS OR INDUSTRY: Pump Co.

11. BIRTHPLACE (County & State, or foreign country): Delmar, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Gordy

14. MOTHER'S MAIDEN NAME: Anna Brewington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Burton B. Gordy (Nephew)
Address: 131 Francis Dr., Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 10 days
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Obstructive Pulmonary emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-10, 1967, to 1-17, 1967, that (I) ~~(we)~~ last saw the deceased alive on 1-17 1967, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Hubert R White, Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Jan. 19 1967

22c. PHYSICIAN'S NAME (Type): Dr. Hubert R. White, Jr.

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 20, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 23 1967

25b. REGISTRAR'S SIGNATURE: Charles Jorge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01469

CERTIFICATE OF DEATH

01466

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 326 Glen Avenue, Apt. 202
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SAMUEL — Middle: (NMI) — Last: Greenfeld

4. DATE OF DEATH: Month: January — Day: 4 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 8, 1899

9. AGE (In years last birthday): 67 yrs
   IF UNDER 1 YEAR — Months: 7 — Days: 26
   IF UNDER 24 HRS. — Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner - clothing mfg.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joel Greenfeld

14. MOTHER'S MAIDEN NAME: Pauline ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):

16. SOCIAL SECURITY NO: 218-16-9171

17. INFORMANT — Address: Mr. David M. Greenfeld (Son) 326 Glen Ave., Apt. 202, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 hr.
DUE TO (b): Coronary Arteriosclerosis. — 6 mo.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/ 19 67 to 1/4 19 67, that (I) (we) last saw the deceased alive on 1/4 19 67, and that death occurred at 7:30 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Jan. 4 /1967

22c. PHYSICIAN'S NAME (Type): Dr. O. J. Burton

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 5, 1967

23c. NAME OF CEMETERY OR CREMATORY: Beth Israel Cemetery

23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR — DATE: JAN 9 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
20 M 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fu... director. Page 4 should be recorded to the Chief Medical Examiner's Office along with form ... Page 5 may be retained ... your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

MARYLAND DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01470 — 01467

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kaywood

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Kaywood
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL Middle SOMERS Last GUNBY Jr.

4. DATE OF DEATH: Month 1 Day 19 Year 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Sept. 29, 1902

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR Months ___ Days ___ IF UNDER 24 HRS Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Repairman

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel S. Gunby

14. MOTHER'S MAIDEN NAME: Lizzie Perdue

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Clara C. Gunby, Salisbury, Maryland (Address)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Earl I. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Earl I. Royer

Address (Street, city, or county)

DATE SIGNED: 1-20-67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/22/1967

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR ADDRESS: Dwight Tull - Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: JAN 24 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01471 01468

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin, Md.
d. STREET ADDRESS: Rt # 3 Box 255
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clayton — Middle — Last GUNN
4. DATE OF DEATH: Month JANUARY — Day 14 — Year 1967

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-28-1907
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: LABORER
11. BIRTHPLACE (County & State, or foreign country): DOTHAN ALA.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Gunn
14. MOTHER'S MAIDEN NAME: Laura Clayton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)
16. SOCIAL SECURITY NO: 51-000 6210A
17. INFORMANT: Hattie Gunn — Address: Berlin Md. Rt # 3 Box 255

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-14, 1967 to 1-14, 1967 that (I) (we) last saw the deceased alive on 1-14 1967 and that death occurred at 12:20 P.M. from causes and on the date stated above.

22a. SIGNATURE: Willard R. Ellis, Jr. M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 1-16-67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-19-67
23c. NAME OF CEMETERY OR CREMATORY: Evergreen
23d. LOCATION (City or Town) (County) (State): Berlin Worc. Md.

24. FUNERAL DIRECTOR: Loretta B. Talley — ADDRESS: Jersey Rd. Rt # 2 Salis. Md.
25a. REC'D BY REGISTRAR DATE: JAN 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01473

CERTIFICATE OF DEATH

01470

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in 1 D 1/8/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico
d. STREET ADDRESS: R.D. (Wetipquin)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HENRY Middle LESTER Last HAMBURY
4. DATE OF DEATH: Month JANUARY Day 23 Year 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 28, 1889
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months 0 Days 25
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Wicomico County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Hambury
14. MOTHER'S MAIDEN NAME: Ella Tyler

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT (Address): Mrs. Alma M. Hambury (Wife) R.D., Quantico, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
204.3
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18) N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-8, 1967 to 1-23, 1967, that (I) (we) last saw the deceased alive on 1-22 1967, and that death occurred at 4:50 PM, from causes and on the date stated above.

22a. SIGNATURE: Robt T Adkins M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 23 Jan 67
22c. PHYSICIAN'S NAME (Type): Dr. Robert T. Adking
22d. ADDRESS: Fruitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 25, 1967
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: JAN 24 1967
25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01474 01471

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2M M 1/66

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: R.F.D. 1 Box 253
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Mary — Middle: E. — Last: HANDY

4 DATE OF DEATH: Month: JANUARY — Day: 30 — Year: 19 67

5 SEX: FEMALE

6 COLOR OR RACE: NEGRO

7 MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8 DATE OF BIRTH: Jan. 16, 1903

9 AGE (In years last birthday): 64 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Factory

11 BIRTHPLACE (County & State, or foreign country): Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Charlie L. Holland

14 MOTHER'S MAIDEN NAME: Anna Lee Dickerson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes give war or dates of service):

16 SOCIAL SECURITY NO.: 215-16-8363

17 INFORMANT Address: Emma V. Porter Westover, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): DIABETIC NEPHROPATHY — Years
DUE TO (c): Diabetes Mellitus — Years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Embolism & PNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o'm. a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/24, 19 67, to 1/30, 19 67, that (I) (we) last saw the deceased alive on 1/29, 19 67, and that death occurred at 3:12 M, from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): OSWALD T. BURTON

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-4-67

23c. NAME OF CEMETERY OR CREMATORY: Tindley Chapel Cem.

23d LOCATION (City or Town) (County) (State): Pocomoke City Wor. Md.

24. FUNERAL DIRECTOR ADDRESS: [signature] New Church, Va.

25a. REC'D BY REGISTRAR DATE: FEB 3 1967

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 rdh 1/25 1/24/67 mh

CERTIFICATE OF DEATH

01475 — 01472

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 226 Catherine St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle Last HARMON
4. DATE OF DEATH: Month JANUARY Day 13 Year 1967
5. SEX: MALE
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/28/1899
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ross Harmon
14. MOTHER'S MAIDEN NAME: Ida Hutt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Doris Harmon — Address: 226 Cathrine St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1/3/67
DUE TO (b): Pericarditis — "
DUE TO (c): Arteriosclerotic Heart Disease — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Subdural Hematoma ; Amputation Rt Leg
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Pt fell 5 days prior to 1/5/67
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Nov, 1966, to Jan., 1967, that (I) (we) last saw the deceased alive on Jan 12 1967, and that death occurred at 5:25 P.M. from causes and on the date stated above.

22a. SIGNATURE: Rufus S Gardner Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan 13 1967
22c. PHYSICIAN'S NAME (Type): RUFUS S GARDNER JR.
22d. ADDRESS: MEDICAL CENTER Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/18/1967
23c. NAME OF CEMETERY OR CREMATORY: Green Acres
23d. LOCATION (City or Town) (County) (State): Salisbury Md.

24. FUNERAL DIRECTOR: Clinton F. Stewart — ADDRESS: Salis - Md.
25a. REC'D BY REGISTRAR DATE: JAN 20
25b. REGISTRAR'S SIGNATURE 1967 Charles Judy

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01476 01473

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSP TAL OR INST.TUTION (If not in hospitol, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): BERLIN
d. STREET ADDRESS: VINE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JULIA Middle TODD Lost HARMON
4. DATE OF DEATH: Month JANUARY Day 16 Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 11, 1918
9. AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): VIDALIA, GA
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: ANGUS TODD
14. MOTHER'S MAIDEN NAME: HELEN PHILLIPS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 213-14-1002
17. INFORMANT: Address: MR. HERBERT HARMON BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma to myocardium, — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
DUE TO (b): pericardium and lung — 2 mos
DUE TO (c): Carcinoma of cervix — 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 17IX

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 1, 1965 to Jan 16, 1967, that (I) (we) last saw the deceased alive on Jan 16 1967, and that death occurred at 4:45 P.M., from causes and on the date stated above.

22a. SIGNATURE: Rufus S Gardner Jr. MD — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/19/67
22c. PHYSICIAN'S NAME (Type): RUFUS S GARDNER JR
22d. ADDRESS: MEDICAL CENTER, SALISBURY MD

23a. BURIAL, CREMATION REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/19/67
23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN
23d. LOCATION (City or Town) (County) (State): BERLIN WOR. MD

24. FUNERAL DIRECTOR: Anna A. Burbage
ADDRESS: Berlin Md
25a. REC'D BY REGISTRAR DATE: JAN 23 1967
25b. REGISTRAR'S SIGNATURE: Frances Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01477

CERTIFICATE OF DEATH

01474

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: R.D. #2 (Ocean City Road)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN — Middle WARREN — Last HENSZEY

4. DATE OF DEATH: Month January — Day 15 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 28, 1920

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months 11 — Days 17
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant

10b. KIND OF BUSINESS OR INDUSTRY: Construction Co.

11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: W. Harland Henszey

14. MOTHER'S MAIDEN NAME: Rowena Wilhite

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): War II

16. SOCIAL SECURITY NO.: 190-18-8429

17. INFORMANT: Mrs. Eugenia G. Henszey (Wife)
Address: R.D. #2, Parsonsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 150X - Coronary Occlusion of Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec, 1966, to 1-15, 1967, that (I) (we) last saw the deceased alive on 1-14 1967, and that death occurred at 6:35 AM, from the causes and on the date stated above.

22a. SIGNATURE: Nevins W. Todd, Jr. M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Jan. 16 /1967

22c. PHYSICIAN'S NAME (Type): Dr. Nevins W. Todd

22d. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 18, 1967

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 19 1967

25b. REGISTRAR'S SIGNATURE: Wesley Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01478

CERTIFICATE OF DEATH

01475

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wicomico Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New York — b. COUNTY: - - -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New York City
d. STREET ADDRESS: - - -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALICE — Middle: (NMI) — Last: HIEBENDAHL

4. DATE OF DEATH: Month: January — Day: 17 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 28, 1882

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months: 6 Days: 19 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): New York City, N. Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: (Unk.) Myer

14. MOTHER'S MAIDEN NAME: (Unk.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. William Hiebendahl (Son) — Address: Upper Ferry Road, R.D., Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): generalized arteriosclerosis — 4 yrs

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): arterial occlusion rt lower extremity

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-3, 1965, to 1-17, 1967, that (I) (we) last saw the deceased alive on Jan. 17 1967, and that death occurred at 11:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: John T. Bulkeley — ATTENDING M.D. PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Jan. 18/1967

22c. PHYSICIAN'S NAME (Type): Dr. John T. Bulkeley

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: Siloam Cemetery

23d. LOCATION (City, town or county) (State): R.D., Salisbury, Maryland Siloam, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judy

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01479 — 01476

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 239 Newton Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: Lee — Last: Hitchens
4. DATE OF DEATH: Month: January — Day: 15 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 18, 1897
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR — Months: 10 — Days: 26 — IF UNDER 24 HRS. Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress-Maker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Wicomico County, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Thomas Elliott
14. MOTHER'S MAIDEN NAME: Lida E. Parsons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 216-40-2508
17. INFORMANT — Address: Mrs. Patricia A. Henry (Foster-Daughter) 239 Newton Street, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma endometrium metastatic — INTERVAL BETWEEN ONSET AND DEATH: over 6 mos.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
172X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May, 1966 to Jan, 1967 that (I) (we) last saw the deceased alive on Jan 15 1967 and that death occurred at 5:45A M, from causes and on the date stated above.

22a. SIGNATURE: Gladys M. Allen, M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Jan 15, 1967
22c. PHYSICIAN'S NAME (Type): Dr. Gladys M. Allen
22d. ADDRESS: 224 N. Division St Salisbury Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR — DATE: JAN 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01480 01477

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Virginia — b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wattsville
d. STREET ADDRESS: Rt. 175
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward — Middle Birch — Last Holland
4. DATE OF DEATH: Month Jan — Day 22 — Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV 28 - 1914
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station oper
10b. KIND OF BUSINESS OR INDUSTRY: Mechanic
11. BIRTHPLACE (County & State, or foreign country): Accomack - Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ira Holland sr
14. MOTHER'S MAIDEN NAME: Stella Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II
16. SOCIAL SECURITY NO.: 229-05-7183
17. INFORMANT: Mrs Norene S. Holland — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Artery Thrombosis
DUE TO (b): Coronary Atherosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1
INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 22, 1967 to Jan 22, 1967, that (I) (we) last saw the deceased alive on Jan 22 1967, and that death occurred at 9P M. from causes and on the date stated above.

22a. SIGNATURE: David J Gilmore
M.D ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 1/22/67
22c. PHYSICIAN'S NAME (Type): David J Gilmore
22d. ADDRESS: Salisbury, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-25-1967
23c. NAME OF CEMETERY OR CREMATORY: Downings
23d. LOCATION (City or Town) (County) (State): Oak Hall - Accomack - Va

24. FUNERAL DIRECTOR: J. N. Fox — ADDRESS: Temperanceville, Va
25a. REC'D BY REGISTRAR DATE: JAN 25 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01481 01478

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only de ay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN To
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 4258 Shelton Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNA — Middle: MARY — Last: HOMER

4. DATE OF DEATH: Month: January — Day: 9 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 6, 1910

9. AGE (In years last birthday): 56 yrs — IF UNDER 1 YEAR: Months: 6 Days: 3 — IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Waitress

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Franklin Edison Riley

14. MOTHER'S MAIDEN NAME: Luella Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No —

16. SOCIAL SECURITY NO: 166-16-2783

17. INFORMANT (Address): Mrs. Brady Franklin (Daughter) 107 Clenwood Avenue, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure
DUE TO (b): A.S.C.V.D.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 422.1
INTERVAL BETWEEN ONSET AND DEATH: (a) 1 hour (b) years (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Dr. Earl L. Royer
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Maryland

22. DATE SIGNED: January 11 /1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 12, 1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery
23d. LOCATION (City or Town) (County) (State): Catonsville, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR — DATE: JAN 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, as the case may be.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01482 — 01479

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 511 Hammond Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle MACE — Last Jones

4. DATE OF DEATH: Month January — Day 30 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 28, 1967

9. AGE (In years last birthday): 0 yrs. — IF UNDER 1 YEAR: Months 0, Days 2 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Billy Conn Jones

14. MOTHER'S MAIDEN NAME: Eileen Louise Gordy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): --

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Mr. & Mrs. Billy C. Jones (Parents) 511 Hammond St., Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 773.5
   (b): Immaturity
   DUE TO
   (c): Prematurity

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): N/A

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/ , 19 , to 1/30 , 1967, that (I) (we) last saw the deceased alive on 1/30 1967, and that death occurred at 1:45 A M, from causes and on the date stated above.

22a. SIGNATURE: William C. Morgan — M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/30/67

22c. PHYSICIAN'S NAME (Type): Dr. William C. Morgan

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 31, 1967

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: FEB 1 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01483

CERTIFICATE OF DEATH

01480

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PRINCESS ANNE
d. STREET ADDRESS: 19
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Edgar — Middle: H — Last: KEMP
4. DATE OF DEATH: Month: JANUARY — Day: 20 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: SEPT. 8, 1894
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSERYMAN
10b. KIND OF BUSINESS OR INDUSTRY: NURSERY
11. BIRTHPLACE (County & State, or foreign country): CONFLUENCE, PENN.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE KEMP
14. MOTHER'S MAIDEN NAME: EFFIE L. BISHOFF

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ROBERT KEMP — Address: PRINCESS ANNE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Pulmonary Infarction
DUE TO
(c): Coronary Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4/20/1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1-12-, 1967 to 1-20-, 1967, that (I) (~~we~~) last saw the deceased alive on 1-20-1967, and that death occurred at 4:23 P.M., from causes and on the date stated above.

22a. SIGNATURE: James L. Clifford M.D. — ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 1-21-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/23/1967
23c. NAME OF CEMETERY OR CREMATORY: MANOKIN PRES. CEMETERY
23d. LOCATION (City or Town) (County) (State): PRINCESS ANNE, MD.

24. FUNERAL DIRECTOR — ADDRESS: LEVIN R. WILSON — PRINCESS ANNE, MD.
25a. REC'D BY REGISTRAR DATE: JAN 24 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A11 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01484

CERTIFICATE OF DEATH

01481

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
a. STREET ADDRESS: 406 Second Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evelyn — Middle: OLGA — Last: Kennedy
4. DATE OF DEATH: Month: January — Day: 1 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 25, 1896
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (County & State or foreign country): Hartford County, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jeremiah Horn
14. MOTHER'S MAIDEN NAME: Henrietta Clayville

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): --
16. SOCIAL SECURITY NO: 213-12-2823A
17. INFORMANT: Mrs Daniel Bergen, Binghamton, N.Y. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial Cardiovascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-27, 19__, to 1-1, 1967 that (I) (we) last saw the deceased alive on 1-1 1967 and that death occurred at 5:38 P.M., from causes and on the date stated above.

22a. SIGNATURE: Wilbur R. Ellis Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-1-67
22c. PHYSICIAN'S NAME (Type): Wilbur R. Ellis, Jr.
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-5-1967
23c. NAME OF CEMETERY OR CREMATORY: Salem Cemetery
23d. LOCATION (City or Town) (County) (State): Jarrettsville, Maryland

24. FUNERAL DIRECTOR: Robert H. Watson
ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR DATE JAN 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones
Robert H. Watson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01485 01482

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bivalve
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALFRED Middle F. Last LARMORE
4. DATE OF DEATH: Month JANUARY Day 26 Year 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/6/1873
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Isaac F. Larmore
14. MOTHER'S MAIDEN NAME: Un Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 220-16-8970
17. INFORMANT: Address Carrie Horner, Bivalve, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: several years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-21, 1967 to 1-26, 1967, that (I) (we) last saw the deceased alive on 1-26 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Wilbur Ellis
M.D ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-26-67
22c. PHYSICIAN'S NAME (Type): Wilbur Ellis
22d. ADDRESS: Salisbury, Wicomico Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/29/67
23c. NAME OF CEMETERY OR CREMATORY: Bivalve Cem.
23d. LOCATION (City or Town) (County) (State): Bivalve, Md

24. FUNERAL DIRECTOR: C. T. Morris
ADDRESS: Bivalve, Md.

25a. REC'D BY REGISTRAR DATE: JAN 31 1967
25b. REGISTRAR'S SIGNATURE: Mary [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01486 01483

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 33 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Fairmount
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Effie; Middle; Last LAYFIELD
4. DATE OF DEATH: Month January; Day 3; Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 23,1892
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): RETIRED NURSES
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): FAIRMOUNT, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WARREN LAYFIELD
14. MOTHER'S MAIDEN NAME: MARGARET HURLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: MRS. JETTA CATLIN FAIRMOUNT, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: few hours
DUE TO
(b): Carcinoma of Breast with
DUE TO
(c): metastasis. — 3 Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 1, 1966 to January 3, 1967, that (I) (we) last saw the deceased alive on January 3 1967, and that death occurred at 8:35 M, from causes and on the date stated above.

22a. SIGNATURE: A. C. Mitchell — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1/3/67
22c. PHYSICIAN'S NAME (Type): Dr. A. C. Mitchell
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/5/1967
23c. NAME OF CEMETERY OR CREMATORY: FAIRMOUNT CEMETERY
23d. LOCATION (City or Town) (County) (State): FAIRMOUNT, MD.

24. FUNERAL DIRECTOR ADDRESS: LEVIN R. WILSON PRINCESS ANNE, MD.
25a. REC'D BY REGISTRAR DATE: JAN 4 1967
25b. REGISTRAR'S SIGNATURE: Murphy Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01487

CERTIFICATE OF DEATH

01484

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: E.6th St. Ext.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Minos — Middle: Levin — Last: LeCates
4. DATE OF DEATH: Month: January — Day: 9 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 25, 1901
9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Minos LeCates
14. MOTHER'S MAIDEN NAME: Ida Nichols

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----
16. SOCIAL SECURITY NO: 716-03-1693
17. INFORMANT — Address: Alice LeCates, Laurel, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO (b): Perforated Carcinomatous Intestinal Obstruction
DUE TO (c): Carcinoma Colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
153.8
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__, to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 4:35 M, from causes and on the date stated above.

22a. SIGNATURE: Richard E. Hughes, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1/10/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-12-67
23c. NAME OF CEMETERY OR CREMATORY: St Stephens
23d. LOCATION (City or Town) (County) (State): Delmar, Del.

24. FUNERAL DIRECTOR — ADDRESS: Charles W. Mariel - Delmar, Del.
25a. REC'D BY REGISTRAR DATE: JAN 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 7,11,12 Film G385 1/24/67 mh

01488

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01485

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oriole
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First OMAR — Middle THOMAS — Last MADDOX

4. DATE OF DEATH: Month 1-12-67 — Day — Year 19

5. SEX: Male

6. COLOR OR RACE: AA

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oriole, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage, with severe facial lacerations
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18): Passenger in auto involved in collision.

20c. TIME OF INJURY Month, Day, Year — Hour a.m. 11:30 xxx 1-12-67 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Deal Island Rd.

20f. (City or town) (County) (State): Somerset, Md.

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: January 16, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 1-15-67

23c. NAME OF CEMETERY OR CREMATORY: St. James

23d. LOCATION (City or Town) (County) (State): Oriole Somerset, Md.

24. FUNERAL DIRECTOR: William A. James Jr.
ADDRESS: James Funeral Home, Princess Anne, Md.

25a. REC'D BY REGISTRAR DATE: JAN 19 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5) 6M 1/66

1 - (M)

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Birth certificate in this bureau

01489

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01486

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Wicomico	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland	b. COUNTY: Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hardela (Rural)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Peninsula General Hospital		d. STREET ADDRESS: R. D. #1		e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ELDRIDGE	BURNIE	MAJORS	January	13	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
Male	White		August 8, 1920	45 46 yrs	4.5	5		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer - Farmer		Hardela, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Frances Majors	Beulah Ida Majors Majors

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO	17. INFORMANT Address
No	— —	216-12-1590	Mrs. Ella M. Majors (wife) R.D. #1, Hardela, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary occlusion.

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

INTERVAL BETWEEN ONSET AND DEATH: hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: January 16, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 17, 1967	Hardela Memorial Cemetery	Hardela, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY, SALISBURY, MD.	JAN 19 1967	J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01490 — 01487

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 804 Hanover St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROBERT — Middle: BERRY — Last: MARTIN

4. DATE OF DEATH: Month: JANUARY — Day: 9 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 15, 1905

9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months: 8 — Days: 24
IF UNDER 24 HRS.: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant

10b. KIND OF BUSINESS OR INDUSTRY: Bakery

11. BIRTHPLACE (County & State, or foreign country): Malta, Ohio

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harris (Harry) Johnson Martin

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No —

16. SOCIAL SECURITY NO: 277-10-9203

17. INFORMANT (Address): Mrs. Hazel A. Martin (Wife) 804 Hanover St. (Apt. #A) Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Polyarthemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Chronic Emphysema

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1-3, 19 67 to 1-9, 19 67 that (I) (we) last saw the deceased alive on 1-8-67 19 ___, and that death occurred at 7:55 A.M. from causes and on the date stated above.

22a. SIGNATURE: John G Bulkeley M.D. — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Jan. 9 /1967

22c. PHYSICIAN'S NAME (Type): Dr. John G. Bulkeley

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 13, 1967

23c. NAME OF CEMETERY OR CREMATORY: Malta Cemetery

23d. LOCATION (City or Town) (County) (State): Malta (Morgan Co.) Ohio

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01491

CERTIFICATE OF DEATH

01488

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: 7 Jewel Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle WILLIAM Last Marvel
4. DATE OF DEATH: Month January Day 14 Year 1967
5. SEX: MALE
6. COLOR OR RACE: White.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 7, 1906
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FUNERAL DIRECTOR
10b. KIND OF BUSINESS OR INDUSTRY: Owner
11. BIRTHPLACE (County & State, or foreign country): Sussex, DELAWARE
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: WILLIAM S. MARVEL Jr.
14. MOTHER'S MAIDEN NAME: BERTHA STURGIS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 221-22-1378
17. INFORMANT (Address): MRS. MARIAN MARVEL, See 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
DUE TO
(b): Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(His hospital)~~ attended the deceased from JAN 13, 1967 to JAN 14, 1967 that (I) ~~(was)~~ last saw the deceased alive on JAN 14 1967, and that death occurred at 11:55 AM, from causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr. M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1/15/67
22c. PHYSICIAN'S NAME (Type): Thomas C. Hill Jr.
22d. ADDRESS: Pine Bluff Rd., SALISBURY, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-18-1967
23c. NAME OF CEMETERY OR CREMATORY: St. Stephen's Cemetery
23d. LOCATION (City or Town) (County) (State): Delmar, Sussex Del.

24. FUNERAL DIRECTOR: Marvel Funeral Home
ADDRESS: Delmar, Del.
25a. RECD BY REGISTRAR DATE: JAN 23 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge
Norman T. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01492

CERTIFICATE OF DEATH

01489

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 mon.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wicomico Nursing Home

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 120 Priscilla St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Henry — Middle: Karlton — Last: McShane

4 DATE OF DEATH: Month: January — Day: 29, — Year: 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 3, 1898

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b KIND OF BUSINESS OR INDUSTRY: Ship B uilder

11 BIRTHPLACE (County & State, or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick Henry McShane

14. MOTHER'S MAIDEN NAME: Joanna Smoot

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): ********

16. SOCIAL SECURITY NO: 215-07-5407

17 INFORMANT: Mrs. H.K. McShane — Address: See #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Steep.
DUE TO (b): generalized arteriosclerosis — 5 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED White at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 66, to Jan 29, 67, that (I) (we) last saw the deceased alive on Jan. 28 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a SIGNATURE: Earl Beardsley. — M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 1/30/67.

22c. PHYSICIAN'S NAME (Type): Earl M. Beardsley M.D.

22d ADDRESS: 207 Maryland Ave., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/31/1967

23c NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park

23d LOCATION (City or Town) (County) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR: George C. Tull — ADDRESS: Salisbury, Md.

25a. REC'D BY REGISTRAR DATE: FEB 1 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01493

CERTIFICATE OF DEATH

01490

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: 402 Market Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First EDNA — Middle ANDERTON — Last Miles
4 DATE OF DEATH: Month JANUARY — Day 5 — Year 19 67

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Dec. 29, 1895
9 AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: --
11 BIRTHPLACE (County & State, or foreign country): Accomack County, Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leander Anderton
14. MOTHER'S MAIDEN NAME: Caroline Jane Andrews

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --
16 SOCIAL SECURITY NO.: 218-20-4006
17 INFORMANT: Address: Mrs Edna Brown, Pocomoke City, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 3 dd
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-28, 1966 to 1-5, 1967 that (I) (we) last saw the deceased alive on 1-5 1967 and that death occurred at 12 P.M. from causes and on the date stated above.

22a SIGNATURE: William B. Ellis Jr. M.D — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 1-5-67
22c PHYSICIAN'S NAME (Type): Wilbur R. Ellis, Jr.
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-8-1967
23c NAME OF CEMETERY OR CREMATORY: Bethany Methodist
23d LOCATION (City or Town) (County) (State): Pocomoke Worcester Md.

24. FUNERAL DIRECTOR: Robert H. Watson
ADDRESS: Pocomoke City, Md.
25a. REC'D BY REGISTRAR DATE: JAN 11 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

Robert H. Watson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01494

CERTIFICATE OF DEATH

01491

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PITTSVILLE
d. STREET ADDRESS: R.T. 22-1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: JERRY Middle: V. Last: MITCHELL
4. DATE OF DEATH: Month: JANUARY Day: 31 Year: 1967
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: FEB. 9, 1886
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (County & State or foreign country): LAUREL DEL
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: DANIEL MITCHELL
14. MOTHER'S MAIDEN NAME: JANE BAILEY

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No No
16. SOCIAL SECURITY NO: 220-07-3560
17. INFORMANT: MRS. JERRY V. MITCHELL Address: PITTSVILLE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Carcinoma of ascending colon
DUE TO
1530
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 1-30, 1967 to 1-31, 1967, that (I) ~~(we)~~ last saw the deceased alive on 1-31, 1967, and that death occurred at 12:35 P.M. from causes and on the date stated above.

22a. SIGNATURE: Robert R. White, Jr. M.D. ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 1-31-67
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2/3/67
23c. NAME OF CEMETERY OR ~~CREMATORY~~: PARSON'S CEMETERY
23d. LOCATION (City or Town) (County) (State): PITTSVILLE WIC MD

24. FUNERAL DIRECTOR: Anna A. Burbage ADDRESS: Berlin Md.
25a. RECD BY REGISTRAR DATE: FEB 2 1967
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (6)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Filed 2/8/67 mh

CERTIFICATE OF DEATH

01495 01492

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
   a. STATE: DELAWARE — b. COUNTY: SUSSEX
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLSBORO
   d. STREET ADDRESS: MAIN ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LORENZO — Middle BURTON — Last Moore

4. DATE OF DEATH: Month January — Day 18 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-27-1880

9. AGE (In years last birthday): 86 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JEWELER

10b. KIND OF BUSINESS OR INDUSTRY: JEWELRY

11. BIRTHPLACE (County & State, or foreign country): DELAWARE

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH B. MOORE

14. MOTHER'S MAIDEN NAME: ANNA ROGERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 22-22-0191

17. INFORMANT — Address: Paul B. Moore, MILLSBORO, DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY.
   IMMEDIATE CAUSE (a): Myocardial Infarction acute severe — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   (b): Coronary Atherosclerosis
   DUE TO
   (c):

   PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-14-, 19__, to 1-18, 1967 that (I) (we) last saw the deceased alive on 1-18-1967, and that death occurred at 7:50 P M, from causes and on the date stated above.

22a. SIGNATURE: James A. Clifford M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-20-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Medical Center Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-21-67

23c. NAME OF CEMETERY OR CREMATORY: MILLSBORO CEMETERY

23d. LOCATION (City or Town) (County) (State): MILLSBORO, SUSSEX, DEL.

24. FUNERAL DIRECTOR — ADDRESS: C. Douglas Wilson, Frankford Del.

25a. REC'D BY REGISTRAR — DATE: JAN 26 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 2M M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in general in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01496

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01493

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Selbyville
d. STREET ADDRESS: Railroad Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First HAZEL Middle BELL Last MUNFORD

4 DATE OF DEATH: Month 1-27-67 Day Year 19

5 SEX: F

6 COLOR OR RACE: AA

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH: 12-11-05

9 AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY: Chickenfactory

11 BIRTHPLACE (State or foreign country): Selbyville, Del.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Paynter A. Rogers

14 MOTHER'S MAIDEN NAME: Sarah Holland

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16 SOCIAL SECURITY NO: 222-05-0467

17 INFORMANT: Hazel S. Pinnell — Address: Selbyville, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
(b): Hypertensive cardio vascular disease — years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

4443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22. DATE SIGNED: February 3, 1967

23a BURIAL ~~CREMATION~~, REMOVAL (Specify)

23b DATE THEREOF: Jan 31, 1967

23c NAME OF CEMETERY OR CREMATORY: Dukes

23d LOCATION (City or Town) (County) (State): Bishop Worcester Md.

24 FUNERAL DIRECTOR: Richard T. Watson — ADDRESS: Watson Funeral Home, Selbyville, Del.

25a REC'D BY REGISTRAR DATE: FEB 6 1967

25b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 & 9 Film 3 24 1/2 pc

01497

CERTIFICATE OF DEATH

01494

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selbyville
d. STREET ADDRESS: Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JOSHUA Middle: L. Last: MURRAY
4. DATE OF DEATH: Month: JANUARY Day: 10 Year: 1967
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 14, 1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: own farm
11. BIRTHPLACE (County & State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David J. Murray
14. MOTHER'S MAIDEN NAME: Martha A. Stephen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 222-05-4178
17. INFORMANT: Elizabeth Boswell Address: Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Spontaneous subarachnoid Hemorrhage
DUE TO: 3 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 10 Days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED White at work ☐ Nat White at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-31, 1966, to 1-10, 1967, that (I) (we) last saw the deceased alive on 1-10 1967 and that death occurred at ____M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-11-67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/12/67
23c. NAME OF CEMETERY OR CREMATORY: Red Men
23d. LOCATION (City or Town) (County) (State): Selbyville Del.

24. FUNERAL DIRECTOR: Peter Whaley ADDRESS: Selbyville, Del.

25a. REC'D BY REGISTRAR DATE: JAN 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

42 — 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01495

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 332 Lake St.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 332 Lake St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First EVELYN Middle MANUEL Last NICHOLS

4. DATE OF DEATH: Month 1-24-67 Day Year 19

5 SEX: F

6 COLOR OR RACE: AA

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-21-1915

9. AGE (In years last birthday): 51 yrs

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY: Domestic

11 BIRTHPLACE (State or foreign country): Ocean City, Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: William F. Manuel

14. MOTHER'S MAIDEN NAME: Louise Pitts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16 SOCIAL SECURITY NO: 213-16-4750

17 INFORMANT: Venitta H. Dashiell — Address: 332 Lake St. Salisbury, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary occlusion

420.1

DUE TO

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22. DATE SIGNED: January 27, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 1-27-67

23c NAME OF CEMETERY OR CREMATORY: Green Acres Pk.

23d LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Md.

24. FUNERAL DIRECTOR: Jolley Funeral Home, Rt. 2, Salisbury, Md.

ADDRESS

25a REC'D BY REGISTRAR DATE: JAN 31 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01499 01496

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Rt. #5, Old Quantico Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First -- Middle FLORENCE Last Parker

4. DATE OF DEATH: Month January Day 7 Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 7, 1881
9. AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months 5 Days 0 — IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State, or foreign country): Pittsville, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dora E. Truitt
14. MOTHER'S MAIDEN NAME: Annie Farlow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mr. Otis R. Parker (Son) Rt. #5, Old Quantico Rd., Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: minutes
442X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Complete heart block — ?
DUE TO (c): Arteriosclerotic C-V-R Disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): N/a
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible] to 1/7, 1967, that (I) (we) last saw the deceased alive on 1/7 1967, and that death occurred at [illegible] M, from causes and on the date stated above.

22a. SIGNATURE: William D Gray — M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan. 7 /1967
22c. PHYSICIAN'S NAME (Type): Dr. William D. Gray
22d. ADDRESS: 334 Camden Avenue, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 9, 1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: JAN 10
25b. REGISTRAR'S SIGNATURE: 1967 Charles Judy

VR A15 (4)
20 M 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01500 — 01497

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 422 Stewart Pl.

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 422 Stewart Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Fannie — Middle: Wright — Last: Parson

4. **DATE OF DEATH**: Month: January — Day: 23 — Year: 1967

5. SEX: F.

6. COLOR OR RACE: C.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 25, 1885

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sidney Wright

14. MOTHER'S MAIDEN NAME: Hanna Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 219-05-3480

17. INFORMANT: Catherine Selby — Address: 409 E. Booth St. Salis- Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Degenerative Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 Mos
DUE TO (b): Generalized Arteriosclerosis — Indefinite
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19 .

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 20 Dec 19 66 to 23 Jan 67 19 ....., that (I) (we) last saw the deceased alive on 23 Jan 19 67, and that death occurred at ....M, from the causes and on the date stated above.

22a. SIGNATURE: E. A. Purnell M.D.

22b. DATE SIGNED: 2/2/67

22c. PHYSICIAN'S NAME (Type): E. A. Purnell MD

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 652 W main St Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/27/1967

23c. NAME OF CEMETERY OR CREMATORY: Green Acres

23d. LOCATION (City, town or county) (State): Salisbury Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Clinton E. Stewart

ADDRESS: Salis- Md.

25a. REC'D BY REGISTRAR DATE: FEB 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judy

1

01501

01498

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8,9 film 4/90 2/1/67 mh

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 112 E. London Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) — First: FRED — Middle: HENRY — Last: PARSONS

4. DATE OF DEATH — Month: January — Day: 24 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 9, 1888

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Junk Dealer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Parsonsburg, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George B. Cyrus Parsons

14. MOTHER'S MAIDEN NAME: Vianna Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Ann W. LeCates (niece) R.D. #2, Box 257, Laurel, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Degenerative Heart Disease c Failure
4221
DUE TO (b) arteriosclerosis
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ______, 19__, to ______, 19__, that (I) (we) last saw the deceased alive on ______ 19__, and that death occurred at 5 AM, from the causes and on the date stated above.

22a. SIGNATURE Carrie Hearn M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED Jan 24 1967

22c. PHYSICIAN'S NAME (Type) Dr. Carrie Hearn — CARRIE HEARN

22d. ADDRESS Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 28, 1967

23c. NAME OF CEMETERY OR CREMATORY: Parsonsburg Cemetery

23d. LOCATION (City, town or county) (State): Parsonsburg, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE JAN 27 1967

25b. REGISTRAR'S SIGNATURE J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2[illegible]hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01502 01499

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 Wks.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Oak Hill Town House
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle RAYMOND — Last PEASE
4. DATE OF DEATH: Month JANUARY — Day 24 — Year 19 67
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec.26,1892
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Distr.
10b. KIND OF BUSINESS OR INDUSTRY: Beer
11. BIRTHPLACE (County & State, or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Raymond S. Pease
14. MOTHER'S MAIDEN NAME: Clementine Hanna
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — Address: Mrs. Louise H. Pease. Sec. 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of lung, with pleural,
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): pericardial & hepatic metastases — INTERVAL BETWEEN ONSET AND DEATH: 6 wks.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary emphysema
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/29, 1966 to 1/24, 1967, that (I) (we) last saw the deceased alive on 1/23 1967, and that death occurred at 5:35 A M, from causes and on the date stated above.

22a. SIGNATURE: William P Sadler M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-25-1967
22c. PHYSICIAN'S NAME (Type): WILLIAM P. SADLER MD
22d. ADDRESS: MED. CTR, SALISBURY, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-26-1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland
24. FUNERAL DIRECTOR — ADDRESS: Hill Funeral Home Salisbury, MAryland
25a. REC'D BY REGISTRAR DATE: JAN 27 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20 M 1/66

- 1 -

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01503 01500

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm. in 1 D 1/17/67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: R.D. #5, Parker Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George — Middle: Edward — Last: Petts, Jr.

4. DATE OF DEATH: Month: January — Day: 27 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 27, 1907

9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months: 3 — Days: 0
IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Baltimore City, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Edward Petts, Sr.

14. MOTHER'S MAIDEN NAME: Margaret Anna Walkling

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO: 212-07-8110

17. INFORMANT: Mrs. Mildred L. Petts (Wife)
Address: R.D. #5, Parker Road, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Cerebral Arteriosclerosis and
DUE TO (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from JAN 17, 1967, to JAN 27, 1967, that (I) ~~(we)~~ last saw the deceased alive on Jan 26 1967, and that death occurred at 4:50 PM, from causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr., M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/27/67

22c. PHYSICIAN'S NAME (Type): Dr. Thomas C. Hill, Jr.

22d. ADDRESS: Pine Bluff Rd, Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 31, 1967

23c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery

23d. LOCATION (City or Town) (County) (State): Westminister, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 30 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01504

CERTIFICATE OF DEATH

01501

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE: MD — b. COUNTY: CRISFIELD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital		d. STREET ADDRESS: 801 Main street	e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3 NAME OF DECEASED (Type or print): First: Robert — Middle: — Last: PEYTON		4. DATE OF DEATH: Month: JANUARY — Day: 15 — Year: 1967	
5 SEX: MALE	6 COLOR OR RACE: Negro	7 MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: MAR. 31, 1921 — 9 AGE (In years last birthday): 45 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY: Sea Food	11. BIRTHPLACE (County & State, or foreign country): Monroe Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Thomas Payton		14. MOTHER'S MAIDEN NAME: Ada Toye	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): Un Known	16 SOCIAL SECURITY NO.	17 INFORMANT — Address: Aaron Peyton - Crisfield Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: Jan 14 ↔ Jan 15
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c):

165K

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 14, 1967 to Jan 15, 1967, that (I) (we) last saw the deceased alive on Jan 15 1967, and that death occurred at 9:10 A.M., from causes and on the date stated above.

22a. SIGNATURE: Youngsik Moon — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑			22b. DATE SIGNED: Jan 15, 67
22c. PHYSICIAN'S NAME (Type): Youngsik Moon		22d. ADDRESS: Peninsula Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 1/18/66	23c. NAME OF CEMETERY OR CREMATORY: Asbury	23d. LOCATION (City or Town): Crisfield (County): (State): Md
24. FUNERAL DIRECTOR: Anthony E Ward	ADDRESS: Crisfield Md.	25a. REC'D BY REGISTRAR DATE: JAN 18 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01505

CERTIFICATE OF DEATH

01502

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 324 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Rt. # 3 (Walston)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: John — Middle: H. (Till) — Last: REED, Jr.

4. DATE OF DEATH: Month: January — Day: 25 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1876

9. AGE (In years last birthday): 90 yrs
IF UNDER 1 YEAR: Months: 8 Days: 5
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Wicomico County, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H. Reed, Sr.

14. MOTHER'S MAIDEN NAME: Nennie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. George W. Taylor (Friend)
Address: Pine Knoll Terrace, R.D. 3, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Recurrent cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO (b): Arteriosclerosis, general — Years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 7, 1966, to January 25 1967, that (I) (we) last saw the deceased alive on January 25 1967, and that death occurred at 8:15 P.M., from causes and on the date stated above.

22a. SIGNATURE: A. C. Mitchell — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-26-67

22c. PHYSICIAN'S NAME (Type): Dr. A. C. Mitchell

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 28, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bethel Church Cemetery

23d. LOCATION (City or Town) (County) (State): Walston, Salisbury, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01506

CERTIFICATE OF DEATH

01503

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 11 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 100 Ellerslie Court
d. STREET ADDRESS: Denton, Maryland - 21629
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: S. — Last: Reinhart
4. DATE OF DEATH: Month: January — Day: 28 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: DEC 16, 1882
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country):
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES MADISON SCHOBER
14. MOTHER'S MAIDEN NAME: LUCY ELLEN BUSCH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS. K. THOS. EVERHAM — Address: DENTON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 Days
DUE TO
(b): Acute Myocardial Infarction — 7 - 8 Days
DUE TO
(c): Generalized Arteriosclerosis — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Osteo-Arthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/17/67, 19__ to 1/28/67, 19__, that (I) (we) last saw the deceased alive on 1/28/67 19__, and that death occurred at 10:05 A. M, from causes and on the date stated above

22a. SIGNATURE: C. H. Winnacott — M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 1/28/67
22c. PHYSICIAN'S NAME (Type): C. H. Winnacott, M.D.
22d. ADDRESS: Deer's Head State Hospital, Box 671, Salisbury

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan 31, 1967
23c. NAME OF CEMETERY OR CREMATORY: Elmwood
23d. LOCATION (City or Town) (County) (State): Shepherdstown W. Va.

24. FUNERAL DIRECTOR: Charles W. Moore — ADDRESS: Denton Md.
25a. REC'D BY REGISTRAR DATE: FEB 6 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01507

CERTIFICATE OF DEATH

01504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Worcester
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: FRANK — Middle: E. — Last: Riley

4 DATE OF DEATH: Month: JANUARY — Day: 18 — Year: 1967

5 SEX: MALE — 6 COLOR OR RACE: White — 7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8 DATE OF BIRTH: Sept 14 1901 — 9 AGE (In years last birthday): 65 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Foreman — 10b KIND OF BUSINESS OR INDUSTRY: Grain Mill — 11 BIRTHPLACE (County & State, or foreign country): Snow Hill, Md. — 12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Curtis E. Riley — 14 MOTHER'S MAIDEN NAME: Nellie Bromley

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): — 16 SOCIAL SECURITY NO: 213 05 0863 — 17 INFORMANT: Address: Mrs. Mildred T. Riley, Newark, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA - LUNG.
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
163X
INTERVAL BETWEEN ONSET AND DEATH: Unk.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-28, 1966 to 1-18, 1967, that (I) (~~we~~) last saw the deceased alive on 1-18 1967, and that death occurred at 4:45 A.M., from causes and on the date stated above

22a. SIGNATURE: J. Tracy Rees M.D. — M D — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 1-19-67
22c PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Jan 21, 1967
23c NAME OF CEMETERY OR CREMATORY: Bowen Methodist
23d LOCATION (City or Town) (County) (State): Newark Md

24 FUNERAL DIRECTOR: Thomas F. Freeman — ADDRESS: Snow Hill, Md.
25a. REC'D BY REGISTRAR DATE: JAN 23 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPART. NT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01508 (VI) 01505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (x)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c LENGTH OF STAY IN 1b: 27 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Grasonville
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Grace — Middle: May — Last: RUTH
4 DATE OF DEATH: Month: January — Day: 8 — Year: 19 67

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: AUG. 1 - 1884
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY: X
11 BIRTHPLACE (County & State, or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM E. TARR
14. MOTHER'S MAIDEN NAME: JULIA

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: Harvey Ruth — Address: Grasonville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CA of lung — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b):
DUE TO
(c):
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 12, 19 66, to January 8, 1967, that (I) (we) last saw the deceased alive on January 8 19 67, and that death occurred at 10:12 P M, from causes and on the date stated above.

22a. SIGNATURE: L. V. Maldve — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1/9/67
22c. PHYSICIAN'S NAME (Type): Dr. L. V. Maldve
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: JAN. 11
23c. NAME OF CEMETERY OR CREMATORY: CHESTER FIELD
23d. LOCATION (City or Town) (County) (State): CENTREVILLE MD.

24. FUNERAL DIRECTOR: Edgar L. Lane — ADDRESS: Church Hill Md.
25a. REC'D BY REGISTRAR DATE: JAN 20 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jagge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01509 01509

1 PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 yrs
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
a STATE: Maryland
b COUNTY: Wicomico
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d STREET ADDRESS: 135 Clyde Avenue
e RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First BERTIE Middle M. Last SAUNDERS
4. DATE OF DEATH: Month JANUARY Day 16 Year 1967

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 10, 1889
9 AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Home
11 BIRTHPLACE (County & State or foreign country): Dorchester Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Hart
14 MOTHER'S MAIDEN NAME: Laura Booze

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): - - -
16 SOCIAL SECURITY NO: Unk
17 INFORMANT: Mrs. Albert Travers, Address: Salisbury, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Myocardial Arrest — INTERVAL BETWEEN ONSET AND DEATH: instant
DUE TO (b): C.V.A. — 12/30/66
DUE TO (c): ___
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 12/30, 1966 to 1/16, 1967 that (I) (we) last saw the deceased alive on 1/15/66 19___, and that death occurred at 6 7/8 M, from causes and on the date stated above.

22a SIGNATURE: Annie Hearn — M.D ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c PHYSICIAN'S NAME (Type): CARRIE Hedrick M.D.
22d ADDRESS: 226 N. Division St Salisbury Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Jan 18, 1967
23c NAME OF CEMETERY OR CREMATORY: St. John Churchyard
23d LOCATION (City or Town) (County) (State): Golden Hill, Dor. Co., Md.

24. FUNERAL DIRECTOR: LeCompte Funeral Service, ADDRESS: Cambridge, Maryland
25a. REC'D BY REGISTRAR DATE: JAN 20 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 1d,e,9 rilm 5 1/24/67 mh

01507

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Resident before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: RD 2

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First VERA Mid XXXX Rose Last Scott

4. DATE OF DEATH: Month 1 Day 2 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March 2, 19 3

9. AGE (In years last birthday) 43 yrs | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Grover C. Holloway

14. MOTHER'S MAIDEN NAME: Ada Wydell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO: 222-20-1876

17. INFORMANT: Harold Scott Address: Parsonsburg, Md. RD 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 810.4 Comp fract. skull - crushed chest — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Train - car accident

20c. TIME OF INJURY Hour a.m. 10:10 p.m. Month, Day, Year 1-2 1967

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) Salisbury (County) (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ] Inspection [X] Inquiry [ ] and in my opinion death resulted from Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Philip A Insley M.D.

EXAMINER'S NAME (Type): Ph. A. Insley

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county)

DATE SIGNED: 1-2-67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/5/67

22c. NAME OF CEMETERY OR CREMATORY: Parsons

22d. LOCATION (City, town, or country) (State): Salisbury, Md

23. FUNERAL DIRECTOR: Peter Whaley ADDRESS: Selbyville, Del

24a. REC'D BY REGISTRAR DATE: JAN 9 1967

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME 5M 1/62

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01511

01508

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 5M 1/62

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 4 wks.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1014 Evergreen Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 1014 Evergreen Ave.
   e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Thomas; Middle: Henderson; Last: Sergeant

4. DATE OF DEATH: January 29, 1967 (Month, Day, Year)

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: December 23,1966

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 1, Days 6. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles D. Sergeant, Jr.

14. MOTHER'S MAIDEN NAME: Marjorie Anne Page

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: C.D. Sergeant, Jr.

Address: See #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial Pneumonitis
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

Sudden death in infancy.

20c. TIME OF INJURY: Hour a.m. p.m. Month Day, Year 19

20d. INJURY OCCURRED: White at work [ ] Not White at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [X] Inquiry [X], and in my opinion death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE OF EXAMINER: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer M.D.

DATE SIGNED: January 30, 1967

Address (Street, city, town or county): Camden Ave. Salisbury, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/31/1967

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

22d. LOCATION (City, town, or country) State: Salisbury, Maryland

23. FUNERAL DIRECTOR: Hill Funeral Home

ADDRESS: Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 1 1967

24b. REGISTRAR'S SIGNATURE: Charles Judge

Bridge C. Hill

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01512

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01503

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

PLACE OF DEATH
a COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institutional residence before admission)
a STATE: Maryland — b COUNTY: Worcester
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
d STREET ADDRESS: 203 N. Second St.
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year 19
MICHAEL	VICTOR	SHAFFER	1-17-67		

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Male	White		2-19-64	2 yrs	11	

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b KIND OF BUSINESS OR INDUSTRY: —
11 BIRTHPLACE (State or foreign country): SALISBURY MD
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: HOWARD C. SHAFFER
14. MOTHER'S MAIDEN NAME: JOYCE SAVAGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT Address: HOWARD C. SHAFFER OCEAN CITY MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Interstitial pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: January 20, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 1/26/67
23c NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK
23d. LOCATION (City or Town) (County) (State): BERLIN WORC. MD

24 FUNERAL DIRECTOR ADDRESS: Burbage Funeral Home, Berlin, Md.
Burbage A. Burbage
25a RECD BY REG. STRAR DATE: JAN 24 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01513 01510

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: Federal St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: FRANCES Middle: J. Last: Shockley
4. DATE OF DEATH: Month: JANUARY Day: 18 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: March 9 1890
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Dressmaker
11. BIRTHPLACE (County & State, or foreign country): Snow Hill, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel R. Johnson
14. MOTHER'S MAIDEN NAME: Mary Ellen Timmons
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): N.C.
16. SOCIAL SECURITY NO.: 220-92-0392
17. INFORMANT Address: Mrs Addie Shockley, Snow Hill Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CEREBRAL EDEMA.
DUE TO (b): ILEO-PONIC [ENTUSSUSCEPTION]
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 5 hrs / 1 day / 1-2-67

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-2, 1967 to 1-18, 1967 that (I) (we) last saw the deceased alive on 1-18, 1967, and that death occurred at 6:45 AM, from causes and on the date stated above.

22a. SIGNATURE: P.J. Jay Rees M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bates Methodist
23d. LOCATION (City or Town) (County) (State): Snow Hill Md.

24. FUNERAL DIRECTOR: Emma F. Timmons
ADDRESS: Snow Hill, Md.
25a. REG'D BY REGISTRAR DATE: JAN 23 1967
25b. REGISTRAR'S SIGNATURE: Charles Quay

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01514

CERTIFICATE OF DEATH

01511

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 34 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tilgman
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Ann — Last: SINCLAIR
4. DATE OF DEATH: Month: January — Day: 22 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/15/1880
9. AGE (In years last birthday): 86 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Talbot Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hugh J. Haddaway
14. MOTHER'S MAIDEN NAME: Rebecca L. Cummings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO: unkn.
17. INFORMANT — Address: Mrs. Helen Dean, Dover, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Lobar pneumonia, lower lobe left lung — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 19, 1966 to January 22 1967, that (I) (we) last saw the deceased alive on January 22 1967, and that death occurred at 12:10 AM, from causes and on the date stated above.

22a. SIGNATURE: W. Maldve, M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 1/23/67
22c. PHYSICIAN'S NAME (Type): Dr. L. V. Maldve
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/25/1967
23c. NAME OF CEMETERY OR CREMATORY: Sherwood Cemetery
23d. LOCATION (City or Town) (County) (State): Sherwood, Md.

24. FUNERAL DIRECTOR: MAURICE E. NEWNAM & SON, EASTON, MD.
ADDRESS
25a. RECD BY REGISTRAR DATE: JAN 25 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01515

CERTIFICATE OF DEATH

01512

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: since Dec. 16, 1966
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pine Bluff State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxford
d. STREET ADDRESS: Box 404
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: Upshur — Last: Thomas

4. DATE OF DEATH: Month: January — Day: 7 — Year: 19 67

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1906

9. AGE (In years last birthday): 60 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): Deck Hand

10b. KIND OF BUSINESS OR INDUSTRY: Ferry Boat

11. BIRTHPLACE (County & State or foreign country): Talbot Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Thomas

14. MOTHER'S MAIDEN NAME: Katie Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: 218-10-0240

17. INFORMANT Address: Records of Pine Bluff State Hospital, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 16, 1966, to Jan. 7, 1967, that (I) (we) last saw the deceased alive on Jan. 7 19 67, and that death occurred at 6:15 pm, from causes and on the date stated above.

22a. SIGNATURE: E. P. Ritchings — M.D — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: Jan. 9, 1967

22c. PHYSICIAN'S NAME (Type): E. P. Ritchings, M.D.

22d. ADDRESS: Pine Bluff State Hospital, Salisbury, Maryland

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: Sarsamersville Cemetery

23d. LOCATION (City or Town) (County) (State): Oxford, Talbot Md.

24. FUNERAL DIRECTOR ADDRESS: Dashiell Funeral Home, Dover St, Easton, Md.

25a. REC'D BY REGISTRAR DATE: JAN 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01516

CERTIFICATE OF DEATH

01513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2430 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Rt. 1, Union Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: Esther — Last: Toadvine

4. DATE OF DEATH: Month: January — Day: 12 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 12, 1887

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months: 10 — Days: 0 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Wicomico County, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred P. Toadvine

14. MOTHER'S MAIDEN NAME: Margaret Esther Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): --

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Nellie T. Wimbrow (Sister), 106 W. Locust St., Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Hypertensive arteriosclerotic cardiovascular disease. — Years
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/18, 1960, to 1/12/, 1967, that (I) (we) last saw the deceased alive on 1/12 19 67 and that death occurred at 11:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: L. V. Maldve — M.D. ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1/13/67

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 15, 1967

23c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery

23d. LOCATION (City, town or county) (State): Fruitland, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01517

CERTIFICATE OF DEATH

01514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 12yrs. 9 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Jane — Last: Tomlin

4. DATE OF DEATH: Month: January — Day: 8, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 13, 1871

9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months: 9 — Days: 25
IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Richmond, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alexander Roundtree

14. MOTHER'S MAIDEN NAME: Mary Jane Unk)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO:

17. INFORMANT: Mr. Walter C. Tomlin (Son)
Address: Box 443, Fruitland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Broncho-Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5-7 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Recent Occlusion of Left Coronary Artery — Several weeks
DUE TO
(c) Genralized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospitol) attended the deceased from March 25, 1954, to January 8, 1967, that (I) (we) last saw the deceased alive on January 8, 1967 and that death occurred at 5 A M, from causes ond on the date stated above.

22a. SIGNATURE: Charles Winnacott M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1/8/67

22c. PHYSICIAN'S NAME (Type): Charles Winnacott, M. D.

22d. ADDRESS: Deer's Head State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 11, 1967

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JAN 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

FOR STATE USE ONLY

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01518 Item 1d Film G505 1/5/67 mh 01515

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parsonsburg
d. STREET ADDRESS: Rd # 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Barbara Middle: Jean Last: Townsend
4. DATE OF DEATH: Month: 1 Day: 2 Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 11, 1946
9. AGE (In years last birthday): 20 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Harold Scott
14. MOTHER'S MAIDEN NAME: Vera Holloway
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): XX
16. SOCIAL SECURITY NO: XX
17. INFORMANT: 218-48-5068 Edward Townsend
Address: Parsonsburg, Md. RD 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Comp. fract skull
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(c)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Train - car accident
20c. TIME OF INJURY: Hour a.m. p.m. Month Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ] Inspection [X] Inquiry [ ] and in my opinion death resulted from: Natural causes [ ] Accident [X] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Philip A Insley
EXAMINER'S NAME (Type): Ph'lip A. Insley
M D
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)
DATE SIGNED: 1-2-67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/5/67
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Md.
23. FUNERAL DIRECTOR: Peter Whaley ADDRESS: Selbyville, Del.
24a. REC'D BY REGISTRAR DATE: JAN 9 1967
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Examiner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01519 01516

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

1. PLACE OF DEATH — COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 315 Martin Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward Middle: Lee Last: Townsend

4. DATE OF DEATH: Month: January Day: 11 Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 9, 1922

9. AGE (In years last birthday): 44 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Eddie Townsend

14. MOTHER'S MAIDEN NAME: Lillie Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 214-16-4014

17. INFORMANT: Mrs. Ethel L. Townsend Address: 315 Martin St. Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fx of Skull
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

8120

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Struck by truck (Pedestrian)

20c. TIME OF INJURY: Hour 10:30 a.m. (p.m.) Month, Day, Year: 1-11 19 67

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rte # 13

20f. (City or town): Salisbury (County): Wic (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

SIGNATURE: Earl L. Dyer M.D

EXAMINER'S NAME (Type): Earl L. Dyer

Address (Street, city, town, or county): Salisbury, Md

DATE SIGNED: 1-13-67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-15-1967

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR: Thomas F. Wallace ADDRESS: Salisbury, Md.

24a. REC'D BY REGISTRAR (DATE): JAN 16 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01520 — 01517

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in general in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hebron
d. STREET ADDRESS: 107 W. Church Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First MARION — Middle COVINGTON — Last TRADER, SR.

4. DATE OF DEATH: Month January — Day 24 — Year 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: June 24, 1898

9 AGE (In years last birthday): 68 yrs — IF UNDER 1 YEAR: Months 7, Days 0 — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b KIND OF BUSINESS OR INDUSTRY: Grocery Store

11 BIRTHPLACE (State or foreign country): Quantico, Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Trader

14 MOTHER'S MAIDEN NAME: Manolia Byrd

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No

16 SOCIAL SECURITY NO: 218-24-5985

17. INFORMANT — Address: Mrs. Mildred Parry (Daughter) 107 W. Church St., Hebron, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: Months, Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of Item 18)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Roger, M.D.
EXAMINER'S NAME (Type): Dr. Earl L. Roger
Address (Street, city, town, or county): 409 Camden Avenue, Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: January 26/1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Jan. 27, 1967
23c NAME OF CEMETERY OR CREMATORY: Siloam Cemetery
23d LOCATION (City or Town) (County) (State): Siloam, Maryland

24 FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND

25a REC'D BY REGISTRAR — DATE: JAN 30 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (3) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01521 Item 6 rtim 1-25-67 mh

CERTIFICATE OF DEATH

01518

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1 PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury c. LENGTH OF STAY IN 1b: 3 Mons.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sp. Hill Rr. Sani.	d STREET ADDRESS: Old Rt., 50 e IS RESIDENCE ON A FARM? YES ☐ NO ☒
3 NAME OF DECEASED (Type or print): First JOHN Middle KEECH Last TRUITT	4 DATE OF DEATH: Month 1 Day 22 Year 19 67
5 SEX: Male 6 COLOR OR RACE: White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH: 3-30-1967 1880 9 AGE (In years last birthday): 86 yrs IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS: Hours / Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 10b. KIND OF BUSINESS OR INDUSTRY: Owner 11. BIRTHPLACE (County & State, or foreign country): Wic. Maryland 12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Eljha James Truitt 14. MOTHER'S MAIDEN NAME: Mary Ann Wimbrow	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): —— 16 SOCIAL SECURITY NO 17. INFORMANT Address: Mrs. Janie F. Truitt, Sec 2	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio vascular Renal disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct, 1966, to 1-22, 1967, that (I) (we) last saw the deceased alive on 1-10 1967, and that death occurred at 9-PM, from causes and on the date stated above.

22a. SIGNATURE: Philip A Insley M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-25-1967
22c PHYSICIAN'S NAME (Type): Dr. Philip A. Insley
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	1-25-1967	Parsons Cemetery	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS: Hill Funeral Home Salisbury, Maryland
25a. REC'D BY REGISTRAR DATE: JAN 26 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

Norman T. Baker

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01522 — 01519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 45 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 612 Smith St.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Wico.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Rt 1
d. STREET ADDRESS: 612 Smith St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GEORGE — Middle: RICHARD — Last: TURNER, SR.
4. DATE OF DEATH: Month: 1 — Day: 1 — Year: 1967
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: DEC. 5, 1882
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: BARBER
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSHUA TURNER
14. MOTHER'S MAIDEN NAME: ELLA HAWKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-10-3812
17. INFORMANT: GEO. R. TURNER, JR. — Address: HAZEL AVE. SALISBURY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the pancreas
DUE TO
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-9, 1966 to 1-1, 1967, that (I) (we) last saw the deceased alive on 11-20 1966, and that death occurred at 11 A M, from causes and on the date stated above.

22a. SIGNATURE: Hubert R. White, Jr., M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-3-67
22c. PHYSICIAN'S NAME (Type): HUBERT R. WHITE, JR.
22d. ADDRESS: Quitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/3/1967
23c. NAME OF CEMETERY OR CREMATORY: PARSONS CEMETERY
23d. LOCATION (City or Town) (County) (State): SALISBURY, MD.

24. FUNERAL DIRECTOR: Doug C. Hill — ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: JAN 5 1967
25b. REGISTRAR'S SIGNATURE: [illegible], Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01523

CERTIFICATE OF DEATH

01520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural - Salisbury
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Valleywood Drive, R.D.#5

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural - Salisbury
   d. STREET ADDRESS: Valleywood Dr., R.D.#5
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	KANE	VALLIANT	January	2	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White		Oct. 26, 1890	76 yrs.	2	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired - Agent	Insurance Co.	Talbot County, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Albert Valliant	Sarah Merrick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	214-10-9604	Mrs. Grace V. White (Daughter) Valleywood Drive, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 26, 19__, to Jan 2, 1967, that (I) ~~(we)~~ last saw the deceased alive on January 2, 1967, and that death occurred at 10 P.M., from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNED
Thomas F. Bibee		☒	☐	☐	Jan. 3, 1967

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Dr. Thomas F. Bibee	Maryland Avenue, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Jan. 4, 1967	Spring Hill Cemetery	Easton, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
[illegible] COMPANY, SALISBURY, MARYLAND	JAN 5 1967	Charles Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01524

CERTIFICATE OF DEATH

01521

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Riverside Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Alice — Middle: — Last: Weaver LANDIS
4 DATE OF DEATH: Month: January — Day: 26 — Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: May 1, 1875
9 AGE (In years last birthday): 91 yrs
IF UNDER 1 YEAR: Months 8 Days 25
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Lancaster, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Kohr
14. MOTHER'S MAIDEN NAME: Mary Landis

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO: 215-36-2087B
17 INFORMANT: Address: Mr. Elmer J. Weaver (Husband) Riverside Drive, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): URINARY TRACT Infection
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~the hospital~~) attended the deceased from Sept., 1965 to Jan 26, 1967, that (I) (~~we~~) last saw the deceased alive on JAN 26 1967, and that death occurred at 10:22 M, from causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr. M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan 26, 1967
22c. PHYSICIAN'S NAME (Type): Dr. Thomas C. Hill, Jr.
22d ADDRESS: Pine Bluff Rd., Salisbury, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Jan. 29, 1967
23c. NAME OF CEMETERY OR CREMATORY: Hebron Cemetery
23d. LOCATION (City or Town) (County) (State): Hebron, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
25a REC'D BY REGISTRAR DATE: JAN 30 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01525

CERTIFICATE OF DEATH

01522

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg
d. STREET ADDRESS: Rt. #1, Box 175
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eugene — Middle: Edward — Last: WELLS
4. DATE OF DEATH: Month: January — Day: 17 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: July 7, 1926
9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee Caroline Farms (Poultry Processing)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Federalsburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas G. Wells
14. MOTHER'S MAIDEN NAME: Mildred M. Nichols

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO: 215-20-2675
17. INFORMANT — Address: Mrs. Thomas G. Wells, Federalsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Retroperitoneal Reticulum Sarcoma with metastases — INTERVAL BETWEEN ONSET AND DEATH: 5 months
200.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 9, 1967, to January 17, 1967, that (I) (we) last saw the deceased alive on January 17 1967, and that death occurred at 6:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: Andrew C Mitchell — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1/17/67
22c. PHYSICIAN'S NAME (Type): Dr. A. C. Mitchell
22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 21, 1967
23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery
23d. LOCATION (City or Town) (County) (State): Federalsburg, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Frampton Funeral Home Federalsburg
25a. RECD BY REGISTRAR DATE: JAN 23 1967
25b. REGISTRAR'S SIGNATURE: J Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01526

CERTIFICATE OF DEATH

01523

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 407 Lincoln Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 407 Lincoln Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GLENNA — Middle WASHINGTON — Last WELLS

4. DATE OF DEATH: Month January — Day 14 — Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 21, 1912
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months 6, Days 23 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dietitian
10b. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (County & State, or foreign country): Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hilary Hearne
14. MOTHER'S MAIDEN NAME: Hattie Brittingham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --
16. SOCIAL SECURITY NO.: 214-10-9365
17. INFORMANT: Mr. William D. Wells (Husband)
Address: 407 Lincoln Avenue, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abdominal carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Typ.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma ovary
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 1965, to Jan. 1967, that (I) (we) last saw the deceased alive on Jan 13 1967, and that death occurred at 9:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Stedman W. Smith
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Jan. 16 /1967
22c. PHYSICIAN'S NAME (Type): Dr. Stedman Smith
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 17, 1967
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY, SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: JAN 19 1967
25b. REGISTRAR'S SIGNATURE: Marvel C. Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1 M

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01527

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01524

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): DOA Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Delaware
   b. COUNTY: Sussex
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millsboro
   d. STREET ADDRESS: 46.3
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print): First CHARLES Middle A. Last White
4. DATE OF DEATH: Month 1-8-67 Day Year 19
5. SEX: M
6. COLOR OR RACE: AA NEG.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-27-32
9. AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES OWENS
14. MOTHER'S MAIDEN NAME: ELLA MAE SPEAKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): KOREAN
16. SOCIAL SECURITY NO.:
17. INFORMANT: MOTHER — Address:

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage due to rupture of liver — INTERVAL BETWEEN ONSET AND DEATH: Minutes
816.4
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Driver of auto involved in head-on collision.
20c. TIME OF INJURY Month, Day, Year: Hour o.m. 3:30 XXX 1-8-67 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 58
20f. (City or town) Selbyville (County) (State) Del.

88

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: January 13, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1-5-67
23c. NAME OF CEMETERY OR CREMATORY: ANTIOCH CEM.
23d. LOCATION (City or Town) (County) (State): FRANKFORD, SUSSEX, DEL.

24. FUNERAL DIRECTOR: D. Douglas Melson
ADDRESS: Watson-Gray-Melson Funeral Home, Frankford, Del.

25a. REC'D BY REGISTRAR DATE: JAN 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01528 Items 1b, 1c Film C385 1/24/68 mh 01525

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Poplar Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRUITLAND 22.1
d. STREET ADDRESS: Poplar Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle HENRY Last WILLIAMS
4. DATE OF DEATH: Month 1 Day 10 Year 1967
5. SEX: M
6. COLOR OR RACE: AA
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-22-1874
9. AGE (In years last birthday): 92 yrs. IF UNDER 1 YEAR: Months 3 Days 11 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate Broker
11. BIRTHPLACE (County & State, or foreign country): Wicomico
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: EMORY WILLIAMS
14. MOTHER'S MAIDEN NAME: MARY Noble
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHN L. WILLIAMS Address: Poplar Street Fruitland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 3 dep
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): generalized arteriosclerosis — >
DUE TO (c):
422.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN, 1962, to 10 JAN, 1967, that (I) (~~we~~) last saw the deceased alive on Jan 8 1967, and that death occurred at 12:10 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robt T Jolkins M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10 JAN 67
22c. PHYSICIAN'S NAME (Type): Robert T. JOKINS MD
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-14-67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
23d. LOCATION (City, town or county) (State): Fruitland - Wico. Md.
24. FUNERAL DIRECTOR: Loretta B Jolley ADDRESS: Jolley Funeral Home Parsley & Rt 13 Salis.
25a. REC'D BY REGISTRAR DATE: JAN 19 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65